# CIGNA HEALTHCARE MEDICAL TRANSITION CARE BENEFIT REQUEST FORM

This form should be filled out by you and the treating physician:
There must be one form filled out for each treatment plan and/or physician:

Effective Date of Coverage:

Employer Name:

Employee Name:

Employee Address:

| City: | State: | ZIP: |
|---|---|---|

Employee Social Security #:

D.O.B.:

Employee Work Telephone:

Dependent Name (If Applicable):

Dependent Address:

| City: | State: | ZIP: |
|---|---|---|

Dependent Social Security #:

D.O.B.:

Relationship to Employee:

Current Insurance Company and Policy #:

Is the current insurance company covering the services you are requesting to be transitioned?

| Yes: | No: |
|---|---|

CIGNA HealthCare Primary Care Selection:

Reason for requesting continued treatment by a CIGNA non-participating provider:

| To Be Completed By Treating Physician | |
|---|---|
| | |
| Name of treating Physician: | |
| | |
| Address of treating Physician: | |
| | |
| Telephone #: | |
| | |
| Diagnosis including ICD-9 codes and description of illness or injury: | |
| | |
| Date of diagnosis: | |
| | |
| **Treatment Plan: Attach additional information as necessary** | |
| | |
| | |
| Duration of treatment: | |
| | |
| List any medications patient is using: | |
| | |
| Physician Signature: | |
| | |
| **To Be Signed By Patient or Guardian** | |
| | |
| I hereby authorize the above physician(s) to provide CIGNA HealthCare or any affiliated CIGNA company with any and all medical records relating to the above-mentioned diagnosis and treatment plans for CIGNA HealthCare's use in evaluating my request for Transition Care Benefits. This Authorization is valid 6 months from the date signed below. | |
| | |
| Signed by Patient or Guardian: | Date: |
| | |
| Return Completed Form to:<br><br>Fax: 602-861-7268 | CIGNA HealthCare of Arizona<br>Health Services Administrative Support<br>8826 N 23rd Avenue<br>Phoenix, AZ 85021 |